

STATE OF MISSOURI COMBINED ENROLLMENT FORM

DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF SPECIAL HEALTH CARE NEEDS (BSHCN)
DEPARTMENT OF SOCIAL SERVICES
MC+

DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
DIVISION OF SPECIAL EDUCATION - FIRST STEPS
DEPARTMENT OF MENTAL HEALTH
DIVISION OF MENTAL RETARDATION/DEVELOPMENTAL DISABILITIES

PART I ENROLLMENT APPLICATION

*COUNTY OF RESIDENCE OF PARTICIPANT			APPLICATION DATE			
FIRST STEPS	SPOE	I.D. Number	<input type="checkbox"/> NEW REFERRAL <input type="checkbox"/> ANNUAL UPDATE <input type="checkbox"/> RE-REFERRAL <input type="checkbox"/> OTHER:			
BSHCN	Local Office	I.D. Number	<input type="checkbox"/> NEW ENROLLMENT <input type="checkbox"/> REAPPLICATION <input type="checkbox"/> REEVALUATION	CHILD IS MEDICALLY: <input type="checkbox"/> ELIGIBLE <input type="checkbox"/> INELIGIBLE	CHILD IS FINANCIALLY: <input type="checkbox"/> ELIGIBLE <input type="checkbox"/> INELIGIBLE	DATE ELIGIBILITY DETERMINED: _____
MRDD	Local Office	I.D. Number	<input type="checkbox"/> NEW ENROLLMENT <input type="checkbox"/> REAPPLICATION <input type="checkbox"/> REEVALUATION	CHILD IS MEDICALLY: <input type="checkbox"/> ELIGIBLE <input type="checkbox"/> INELIGIBLE	CHILD IS FINANCIALLY: <input type="checkbox"/> ELIGIBLE <input type="checkbox"/> INELIGIBLE	DATE ELIGIBILITY DETERMINED: _____
MC+ For Kids (Medicaid)		<input type="checkbox"/> NEW ENROLLMENT <input type="checkbox"/> REAPPLICATION <input type="checkbox"/> PENDING <input type="checkbox"/> CURRENT <input type="checkbox"/> N/A				

*Ö SECTION A. Child Information

LAST NAME	FIRST NAME			MI	DOB	KNOWN AS (AKA)
STREET ADDRESS, APARTMENT NUMBER, P.O. BOX	CITY/TOWN	STATE	ZIP CODE	A/C	TELEPHONE #	MOTHER'S MAIDEN NAME
Child's Native Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:						
Child's School District:						

Ö SECTION B. Parent/Legal Guardian Information

1. *Name: _____ *Address: _____ <div style="display: flex; justify-content: space-between; margin-top: 5px;"> Street City/Town State Zip Code </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> *Home Telephone: () *Office Telephone: () Other Telephone: () </div>				
2. *Name: _____ *Address: _____ <div style="display: flex; justify-content: space-between; margin-top: 5px;"> Street City/Town State Zip Code </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> *Home Telephone: () *Office Telephone: () Other Telephone: () </div>				
*Native Language Spoken at Home: _____ Interpreter Needed? _____				

*√ Intake Coordinator/Interviewer:	Address:	Telephone:
*√ Ongoing Service Coordinator:	Address:	Telephone:

SECTION C. List all persons (including participant) who live in your household and provide requested information for each individual.

Name	*Relationship	*DOB	Marital Status	*Gender	*✓ Race/Ethnicity	Nationality	*Migrant/Homeless	*✓ Education Level	Preg (Y/N) # Fetuses	US Citizen (Y/N)	PCP (Y/N)	* SSN#	*DCN	Ins Y/N	X if applying for MC+
Child:					/										
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TOTAL HOUSEHOLD SIZE _____ ADJUSTED HOUSEHOLD SIZE _____ TOTAL APPLYING FOR MC+ _____

SECTION D. Income Verification

* ✓ Are you or someone else in your household currently employed? ☐ YES If yes who _____ ☐ NO

*Total Household Gross MONTHLY Income: \$ _____

Proof of Income was verified (check stub, letter, tax form, or written statement) by _____
Signature

If no income, how are you supported? _____

Is this month's income the same as the previous three months? ☐ YES ☐ NO

*Are you currently paying child care to maintain employment? ☐ YES ☐ NO

Is the child: Blind/Disabled? ☐ YES ☐ NO Receiving SSI? ☐ YES ☐ NO

Do you pay for care of an incapacitated adult? ☐ YES ☐ NO

Does anyone living in the household pay support payments? ☐ YES ☐ NO

Do you have any extraordinary expenses? ☐ YES ☐ NO

✓ Federal Poverty Level ☐ <0 -100% ☐ <101-125% ☐ <126-133% ☐ <134-150% ☐ <151-185%
☐ <186-200% ☐ <201-250% ☐ <251-300% ☐ >301-400% ☐ >401%

COMMENTS:

SECTION E. Medical Insurance Summary (complete a new form for each insurance coverage)

1. CHILD IDENTIFYING INFORMATION:			
Name: _____		D.O.B.: _____	
DCN: _____		MO _____	
Address: _____		Street _____ City/Town _____ Zip Code _____	
*2. MC+ ENROLLMENT INFORMATION:			
Complete One: Current Coverage Effective Date: _____ Pending Application Date: _____ Not Financially Eligible Date of Denial: _____		Did participant lose health insurance coverage in the past 3 months? <input type="checkbox"/> YES <input type="checkbox"/> NO Date coverage ended: _____ Reason for loss of insurance: _____	
MC+ Plan _____		Contact Info _____	
*3. POLICYHOLDER INFORMATION:			
Name: _____		Relationship: _____ Telephone: () _____	
Address: _____		Street _____ City _____ State _____ Zip Code _____	
*4. INSURANCE COMPANY INFORMATION:			
Name: _____		Telephone: () _____	
Address: _____		Street _____ City _____ State _____ Zip Code _____	
Check As Applicable: Is this Coverage: _____ Through Employer _____ Self Purchase _____ Union _____ HMO Policy _____ PPO Policy _____			
*5. POLICY NUMBER: _____ Member/I.D. #: _____ Group/Acct. #: _____			
Effective date dependent will be covered under policy: _____ End Date: _____			
6. EMPLOYER INFORMATION:			
*Name of Employer: _____			
Address: _____			
Street _____ City _____ State _____ Zip Code _____			
Telephone: () _____ Start Date: _____			
7. COVERAGE INFORMATION:			
Check As Applicable: A. Second Insurance Company Coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO B. Therapy Services Covered: <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Speech C. Co-Payments? <input type="checkbox"/> YES <input type="checkbox"/> NO Office Visit Amt: \$ _____ Specialist Amt: \$ _____ Emergency Room Amt: \$ _____ Other Amt: \$ _____ Prescriptions Amt: \$ _____ DME Services Amt: \$ _____ D. *Deductibles? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, Amt: \$ _____ E. Maximum Out of Pocket Expense \$ _____		F. Is there a pre-existing clause? <input type="checkbox"/> YES <input type="checkbox"/> NO Effective Date: _____ G. Is there a dental plan? <input type="checkbox"/> YES <input type="checkbox"/> NO Name of plan if different: _____ Effec. Date: _____ Term. Date: _____ H. Lifetime maximum? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ _____ per person \$ _____ per family I. Conditions/Exclusions: _____	

Confirmation of Information: _____ (Signature) _____ (Date)

Check One: ☐ First Steps Intake / Service Coordinator ☐ BSHCN Coordinator
☐ DFS Caseworker ☐ DMH Staff